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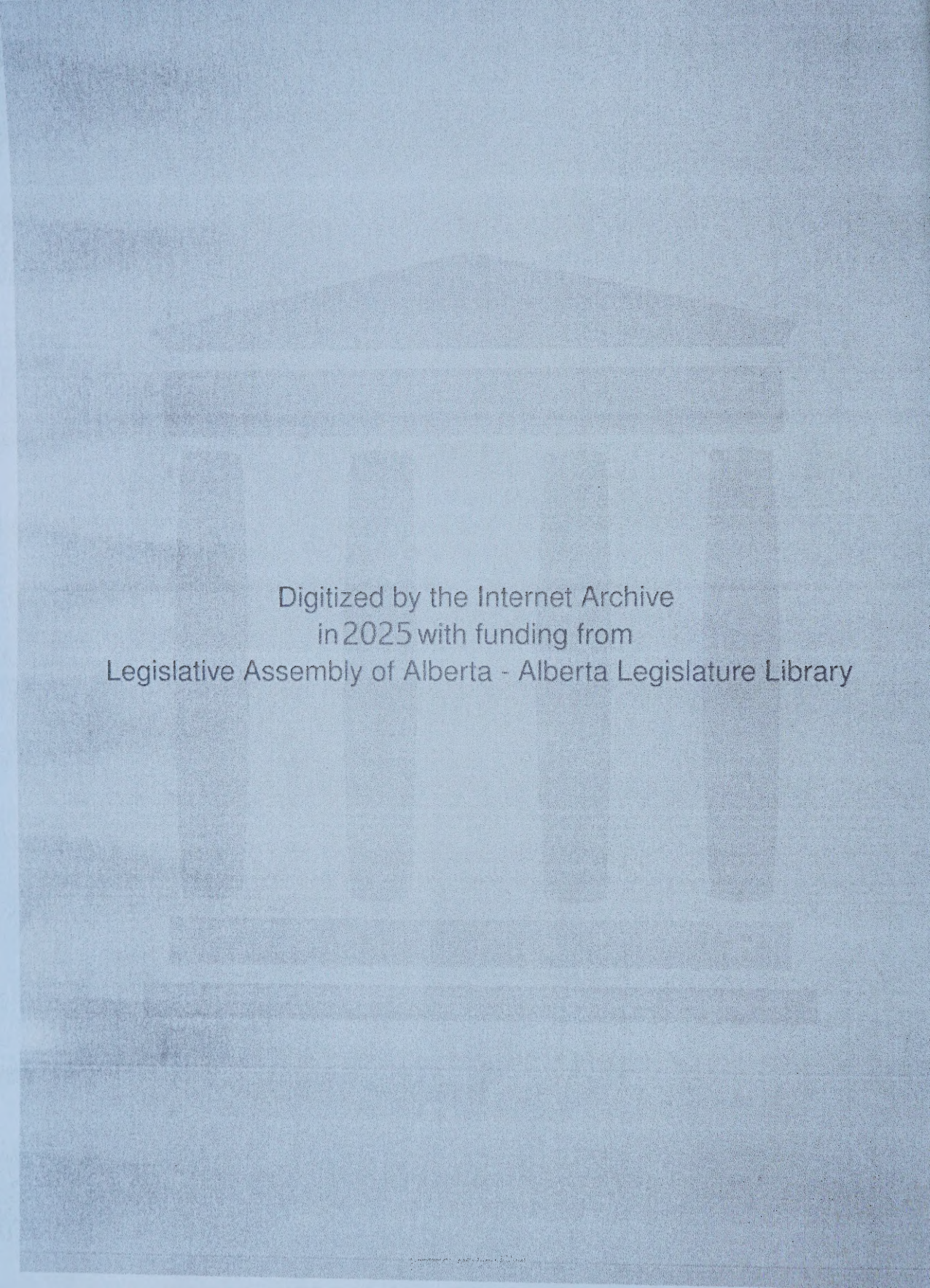
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APPENDIX A OUTPATIENT DEPARTMENTS FEES AND  
SERVICES: RE UNIVERSITY OF ALBERTA HOSPITAL  
DOCTORS OUTPATIENT FEES

Alberta Hospital Services Commission

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Out-patient and emergency services of the University Hospital and  
other departments of the University of Alberta.

Emergency Services

Family Practice

General Medical Clinics

Special Disease Clinics

Sections concerning the management of patients in the hospital and  
out-patient services are designated below. This document was  
prepared for the consideration of the out-patient services of the  
hospital.

## Emergency Services

### APPENDIX A OUT-PATIENT DEPARTMENTS FEES AND SERVICES

RE: UNIVERSITY OF ALBERTA HOSPITAL -  
RECOVERY OF DOCTORS' OUT-PATIENT FEES

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1266



## APPENDIX A OUT-PATIENT DEPARTMENTS FEES AND SERVICES

RE: UNIVERSITY OF ALBERTA HOSPITAL -  
RECOVERY OF DOCTORS' OUT-PATIENT FEES

Out-patient and emergency services of the University Hospital can be broken down into four basic categories:

1. Emergency Services
2. Family Clinic
3. General Disease Clinics
4. Special Disease Clinics

Information concerning the disposition of physician's fees generated and payments to the hospital are recapitulated below. This discussion does not take into consideration the out-patient services fees earned by the hospital.

### 1. EMERGENCY SERVICES:

-- physician's fees generated are billed through the names of the two full-time physicians, employed by the hospital to operate the emergency services. For the most part these fees are earned by licensed medical residents under supervision of a physician, and the fees earned by the two full-time physicians. Other individual medical staff members performing services in emergency often bill under their own numbers and receive reimbursement personally.

-- the two full-time physicians are on salary; licensed residents receive \$80/shift.

-- fees generated are credited to the Triage Officers Fund.

-- revenues to this fund are less than the salaries and shift payments made from it. Therefore there is no residual portion of the physicians fee paid to the hospital.

-- the hospital was recently advertising for two additional full-time physicians for this department.





## 2. FAMILY CLINIC

- there are three full-time salaried general practitioners.
- it is entirely divorced from the hospital in almost every way except geographically.
- the salaried physicians are not allowed to supplement their incomes in any way, outside of the university salaries paid.
- of the fees generated:
  - 5% goes to an accounting firm for bookkeeping,
  - 15% is paid to the University of Alberta Hospital as partial payment of overhead incurred by the hospital; actual costs are between \$30,000 - \$50,000 of which approximately \$16,000 was recovered in 1970,
  - 5% is paid to the Research and Development Fund of the Faculty of Medicine,
  - 75% goes to The University of Alberta to defray part of the doctor-salary costs.

## 3. GENERAL DISEASE CLINICS

- General disease clinics are held regularly in the out-patient department of the University of Alberta Hospital. The entire medical staff of the hospital is involved. Its main function is for teaching purposes.
- A principle of this clinic is that the medical staff themselves do not benefit from fees generated by services rendered in this clinic.
- Since the AHCIC ruling of requiring a medical staff member to be physically present in order to bill for the services of a resident, the fees generated by this clinic have been reduced to about 1/3 their previous level.





-- this is the largest single fund generated in the hospitals clinics.

-- fees generated are disbursed as follows:

- approximately 10% to the University of Alberta Hospital for administration (pay actual costs).
- balance to Medical Staff Academic Fund for medical education purposes.
- no revenue to physicians.

#### 4. SPECIAL DISEASES CLINICS:

-- For many years the Medical Faculty has provided "Specific Disease Clinics" for the purposes of Education and Research. Each clinic is under the direction of a specialist in that field who donates his time for the benefit of students and patients. e.g. Rheumatic Disease Clinic, Thyroid Disease Clinic, etc.

-- A great deal of work is done by House Staff with and without direct supervision. - where supervised fees are billed.

-- A basic principle is that no funds will find their way back to the physician - faculty member. However, there are apparently some instances where physicians are billing for services under their own number and thus being personally paid. The argument being given by these physicians is that these cases are their private patients and they are being provided to the clinic as a convenience to the students and the medical school.

-- Fees collected are disbursed through the Professional Services Trust Fund as follows:

- 25% goes to the University of Alberta Hospital in lieu of rent and overhead,
- 5% to an accounting firm for administration,
- 70% to Research and Development as determined by the Board of the Trust.





From the above descriptions it can be seen that the University of Alberta Hospital does receive a portion of some of the fees generated in these clinics and services.

1. emergency services - all billings under names of Triage Officers.
2. family clinic - 15% of fees
3. general disease clinic - administration costs covered; approximately 10% of fees.
4. special disease clinics: 25% of fees, in lieu of rent.

The only fees which the hospital does not receive some portion of, are those billed for privately by individual physicians, for the most part in emergency and general disease clinics and in a few cases the special disease clinics.

It would therefore appear that the major teaching hospital of this province is receiving at least a portion of the physician's fees generated in its out-patient departments or clinics. This is not as complete an approach as used at the Winnipeg General Hospital in that some physicians fees are not billed through the hospital mechanisms.

Two possible approaches are seen to establishing a uniform policy to cover all physician out-patient service fees in the teaching hospital, (and any other hospital if the recommendations of the "Task Force" are to be followed):

1. All physicians using hospital out-patient facilities would be required to submit their claims through the hospital. The hospital would collect for these billings from the Insurance Commission and make disbursements of receipts, retaining a percentage of fees collected in order to cover operating overheads.

- the calculation of overhead could be,
  - a. a general percentage e.g. 25%.
  - b. costed out in detail (some out-patient clinics are more costly to operate than others, e.g. family clinics as special clinics).





- for ease of administration and to hold down administration costs method (a) would be recommended.
- the fee hold-back would not necessarily be constant for all hospitals, and would be negotiable.

2. Establish a two-value schedule of fees to differentiate services provided in hospital facilities and the physicians private office.

- this approach would likely be the least costly from an administrative point of view, however, it would also be the most difficult to initiate i.e. new fee schedules would have to be negotiated.

Of the methods above, the percentage hold-back approach would be the easiest to implement and would perhaps best portray the physician's involvement in overhead costs. It must be pointed out that the hold-back would not represent all overhead costs since part of the cost of emergency services etc. are attributable to the hospital for which they receive a fee in accordance with the "Hospital Out-Patient Services Schedule of Charges". The problem is therefore, one of joint cost allocation which can only be resolved through subjective decisions and thus open to negotiation.

It is recommended that the introduction of a compulsory physician out-patient service fee hold-back system not be introduced only in teaching hospitals but in all hospitals providing out-patient services.

There are several reasons for making this recommendation:

- there are problems in defining a teaching hospital.
- originally the teaching hospital hold-back concept as in Manitoba, likely grew out of concern (at least in part) for fees generated by interns and residents. With the AHSC ruling in effect in Alberta (i.e. an attending physician must be present if the services of house staff are to be billed for), the billings from the teaching hospital out-patient department have been substantially reduced. Therefore, the





house staff fee problem is no longer so critical.

- to single out only the medical staff of the teaching hospitals would not be equitable ruling, since the underlying problem of providing support services and facilities to physicians using the out-patient department is common to all hospitals.

There is no factor in applying a hold-back system only to the University of Alberta Hospital which must be considered. That is, since the University of Alberta Hospital employs directly the only general practitioners on the medical staff, a hold-back applicable only to the University of Alberta Hospital would not effect the general practitioner who is already low on the income scale for physicians.

If a fee hold-back system were to be instituted in all hospitals it is true the earnings of the general practitioner would be most effected (as mentioned in Dr. Clark's letter of November 26, 1971, page 3). However, it is believed the fee schedules are to be revised by the professional association with the objective of bringing the general practitioners earnings more in line with those of the specialists and to reduce the excessive earnings cases such as pathology and radiology.

In the long run, a system of fee hold-back in all hospitals with revised general practitioner fees would bring about a more equitable situation to all concerned.

Possible counter-moves by the medical profession could be:

- increased pressure to pass the charge along by raising all fee schedules.
- make second billings to the patient for the withheld portion of the fee.
- change made of medical practice by:
  - a. refusing to see patients in out-patient departments or to provide emergency services at any time.
  - b. carry out all or almost all services in the out-patient department, i.e. transferring as much of his practice as possible to the hospital facilities.



It must also be remembered that a policy change in this area will have an effect on the future development of community health centres. In this regard it may be beneficial to review the Interim Report and/or wait for the final report of Dr. Hastings' study on ambulatory health care. The final report of the Hastings Committee is expected in July 1972.

The January 14, 1972 Edmonton Journal quotes the Interim Report as saying:

*"The report also rapped government for falling into the trap of passively accepting existing doctors' fee schedules as the basis for provincial medicare payments.*

*The fee schedules encourage doctors to use hospital facilities as much as possible, thus avoiding overhead in their own offices.*





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